Complete Summary

GUIDELINE TITLE

Weight management counseling of overweight adults.

BIBLIOGRAPHIC SOURCE(S)

Nawaz H, Katz DL. American College of Preventive Medicine Practice Policy statement. Weight management counseling of overweight adults. Am J Prev Med 2001 Jul;21(1):73-8. [75 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Overweight and obesity

GUIDELINE CATEGORY

Counseling
Management
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel

Dietitians
Nurses
Physical Therapists
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To present a practice policy statement on weight management counseling of overweight adults

TARGET POPULATION

Counseling/Prevention
General adult population

Management
Overweight and obese adults

INTERVENTIONS AND PRACTICES CONSIDERED

Counseling/Prevention

1. Dietary and physical activity counseling
2. Measurement of body mass index (BMI)
3. Weight monitoring

Treatment

1. Moderate physical activity
2. Energy-reduced or low-calorie diet (Note: other types of diet, such as low-carbohydrate or high-protein diets are considered but not recommended)
3. Surgery (e.g., surgical gastroplasty and gastric bypass)
4. Pharmacotherapy, such as sibutramine and orlistat
5. Cognitive-behavior therapy

MAJOR OUTCOMES CONSIDERED

- Prevalence of overweight and obesity
- Short-term and long-term weight loss
- Morbidity, especially cardiovascular and diabetic incidences, related to obesity
- Mortality related to obesity
- Health costs attributed to obesity
- Adverse effects of weight loss methods

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developer performed a MEDLINE search and used the reference lists from key articles to collect evidence.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

It is not known whether weight-loss interventions are cost effective or cost beneficial, given that weight loss is generally not sustained. Studies suggest that a sustained 10% weight loss is expected to extend life expectancy by 2–7 months and to reduce expected lifetime medical care costs of chronic medical conditions (diabetes, hypertension, hypercholesterolemia, coronary artery disease, and stroke) by $2200–$5300. One study suggests that surgical intervention may be more cost effective in the long run than medical treatments because of persistent weight reduction after surgery. However, in that study the average cost per pound of weight loss was approximately $250.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Guidelines/recommendations from the following groups were reviewed:

- U.S. Preventive Services Task Force
- Canadian Task Force on Preventive Health Care
- National Institutes of Health (NIH) National Heart, Lung, and Blood Institute
- American Dietetic Association
- American Academy of Family Physicians
- American Heart Association

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Independent of weight or body mass index (BMI), all adult patients should consistently receive counseling about healthful dietary and physical activity patterns in the context of primary care. Such counseling should be reinforced in the context of specialty care (e.g., cardiology) as dictated by clinical judgment and discretion. Periodic measurement of body mass index (weight in kilograms/height in meters^2) is recommended for all adults. Although an emphasis on health-promoting behaviors may be preferred to an emphasis on weight per se, weight monitoring is considered useful to both clinician and patient in gauging the adequacy of behavioral interventions. The American College of Preventive Medicine (ACPM) endorses the practical guidelines of the National Institutes of Health in advising obese and overweight patients (National Institutes of Health [NIH] National Heart, Lung, and Blood Institutes, 1998). Moderate physical activity for 30 to 45 minutes, at least 3 to 5 days per week, should be encouraged for all patients unless specifically contraindicated. Overweight or obese patients should be counseled regarding an energy-reduced, or low-calorie diet (800 to 1500 kcal/day). Surgery should be reserved for severely obese subjects (generally, body mass index >40). Evidence available to date is insufficient to support any specific behavioral therapy, short-term use of pharmacotherapy, or chronic pharmacotherapy; such interventions should be individualized in accord with clinical judgment. Clinicians are encouraged to apply prevailing models of behavior modification, such as the Stages of Change, in support of counseling by clinicians for weight control. Physicians should be attentive to the stigmatizing effects of obesity and should strive to address weight-control counseling of patients in a manner that supports, rather than erodes, patients´ self-esteem (Katz, 2001). As a large proportion of obese patients will have engaged in multiple unsuccessful weight-control efforts, the American College of Preventive Medicine encourages an approach to counseling that distinguishes between blame for weight gain and responsibility for weight control, in an effort to prevent exacerbation of the well-documented psychological sequelae of obesity. Specifically, those patients with multiple failed attempts at weight control should receive counseling directed at the impediments to weight control and strategies

for circumventing them. The American College of Preventive Medicine encourages further research into the pathogenesis and treatment of obesity, as well as initiatives to enhance physician–patient interaction regarding weight management and to minimize barriers to such counseling. Ultimately, for obesity control at the population level, environmental modification to support healthful eating and levels of physical activity is likely to be necessary.

The lack of clearly effective treatment for obesity once established requires that obesity prevention be addressed consistently in clinical practice. Counseling by clinicians to encourage health-promoting dietary patterns and levels of physical activity in all patients is therefore warranted, both as a means to control weight and to confer health benefits by other means.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- There is conclusive evidence that obesity is associated with increased morbidity and mortality and imposes a substantial economic burden both at the individual and societal level. Weight reduction, at least in the short term, has been shown in small prospective cohort and randomized controlled trials to confer beneficial health effects.
- Studies suggest that a sustained 10% weight loss is expected to extend life expectancy by 2 to 7 months and to reduce expected lifetime medical care costs of chronic medical conditions (diabetes, hypertension, hypercholesterolemia, coronary artery disease, and stroke) by $2200-$5300.

POTENTIAL HARMS

Current weight-loss methods are not without risk. Weight cycling because of repeated dieting has been associated with cardiovascular events and increased mortality in retrospective cohort studies, although a meta-analysis failed to corroborate those findings. In the past, very low calorie diets were associated with cardiac arrhythmia related to myocardial protein loss and electrolyte abnormalities. Other significant side effects of very low calorie diets include gout,

gallstones, fatigue, hair loss, cold intolerance, and diarrhea, but risks are lower and generally manageable in a supervised medical setting with adequate replenishment of essential amino acids and micronutrients. Gastroplasty is associated with gastric ulceration, perforation, and bowel obstruction, but such risks have declined with the advent of laparoscopy.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 Jul

GUIDELINE DEVELOPER(S)

American College of Preventive Medicine - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Preventive Medicine (ACPM)

GUIDELINE COMMITTEE

Practice Guidelines Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Authors: Haq Nawaz, MD, MPH, David L. Katz, MD, MPH

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American College of Preventive Medicine (ACPM) Web site.

Print copies: Available from the American College of Preventive Medicine, 1307 New York Ave, N.W., Suite 200, Washington, DC 20005-5603.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on July 19, 2002. The information was verified by the guideline developer on August 29, 2002.

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